RECIPIENT REQUEST FOR RECORD CORRECTION/AMENDMENT

Recipient's Name: _____

Medicaid/Nevada Check Up ID #: _____

Date of Entry to be Amended: _____

Describe the Protected Health Information in your Division of Health Care Financing and Policy (DHCFP) record that is incorrect or incomplete. Include correct information to make your DHCFP record more accurate or complete:

_____

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_____

Do you need this correction/amendment sent to anyone to whom we may have disclosed the information in the past? If so, please indicate the name(s) and address(es) of the individual(s) or organization(s).

Name and Address: _____

_____

_____

_____ _____

Signature of Recipient or Personal Representative | Date

_____ _____

Printed Name of Recipient or Personal Representative | Relationship to Recipient or Authority to Act on Their Behalf

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[DHCFP Personnel: Upon receipt of completed Form from the recipient:
(1) Attach page 2 and complete upper portion of page 2 and
(2) Forward the request to the Case Management Supervisor for review and disposition.

FOR DHCFP's USE ONLY:

Recipient's Name: _____

Medicaid/Nevada Check Up ID #: _____

Date of Request: _____

Date Amendment Request Received: _____ Amendment Status: ___ Accepted ___Denied

If Amendment Request is denied, check reason for denial:

_____ The Protected Health Information was not created by DHCFP.

_____ The Protected Health Information is not available to the recipient for inspection as required by law (e.g., psychotherapy notes).

_____ The Protected Health Information is not part of the recipient's DHCFP record.

_____ The Protected Health Information is accurate and complete.

Name of DHCFP Staff Member: _____ Title: _____

Comments of [Case Management Supervisor/Privacy Officer]: _____

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_____ _____

Signature of
[Case Management Supervisor/Privacy Officer]

Date